

Deputy Sheriff: Aetna/Express Scripts

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2015 – 12/31/2015

Coverage for: Family | Plan Type: PPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.kingcounty.gov/employees/benefits/YourKingCountyBenefits or by calling 206-684-1556.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$50 person / \$150 family (gold level) \$200 person / \$600 family (silver level) Doesn't apply to prescription drugs, preventive care or hearing aids.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For network providers \$375 person / \$1,125 family (gold level) \$800 person / \$1,600 family (silver level) For out-of network providers \$1,600 person / \$3,200 family (gold level) \$2,800 person / \$3,600 family (silver level)	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Prescription drugs, deductibles, copayments, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.kingcare.com or call 1-800-654-3250 for a list of network providers.	If you use a network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term <u>network</u> , in-network, preferred, or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .

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Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	10% (gold level)	30% (gold level)	_____none_____
	Specialist visit	20% (silver level)	40% (silver level)	_____none_____
	Other practitioner office visit	10% (gold level) 20% (silver level) for acupuncture, chiropractic, hypnotherapy and massage therapy	30% (gold level) 40% (silver level) for acupuncture, chiropractic, hypnotherapy and massage therapy	Coverage limited to 60 visits/year for any combination of acupuncture, hypnotherapy and massage therapy Coverage limited to 33 visits/year for chiropractic
	Preventive care/screening/immunization	No charge	30% (gold level) 40% (silver level)	_____none_____
If you have a test	Diagnostic test (x-ray, blood work)	10% (gold level)	30% (gold level)	_____none_____
	Imaging (CT/PET scans, MRIs)	20% (silver level)	40% (silver level)	_____none_____

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If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.express-scripts.com .	Generic drugs	\$7 copay (gold) \$7 copay (silver) retail prescription \$14 copay (gold) \$14 copay (silver) mail-order prescription	\$7 copay (gold) \$7 copay (silver) plus remaining balance after pharmacy is paid at network rate	Coverage limited to a 30-day supply (retail prescription) and 31-90 day supply (mail-order prescription through Express Scripts only)
	Preferred brand drugs	\$20 copay (gold) \$30 copay (silver) retail prescription \$40 copay (gold) \$60 copay (silver) mail-order prescription	\$20 copay (gold) \$30 copay (silver) plus remaining balance after pharmacy is paid at network rate	Coverage limited to a 30-day supply (retail prescription) and 31-90 day supply (mail-order prescription through Express Scripts only)
	Non-preferred brand drugs	\$30 copay (gold) \$60 copay (silver) retail prescription \$60 copay (gold) \$120 copay (silver) mail-order prescription	\$30 copay (gold) \$60 copay (silver) plus remaining balance after pharmacy is paid at network rate	Coverage limited to a 30-day supply (retail prescription) and 31-90 day supply (mail-order prescription through Express Scripts only)
	Specialty drugs	According to the generic, preferred and non-preferred drug categories	Only available through Accredo Health after one courtesy fill at retail pharmacy	Coverage limited to a 30-day supply (mail-order prescription through Accredo Health only).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% (gold level)	30% (gold level)	Preauthorization required to receive coverage. Diagnostic services not covered unless medically necessary.
	Physician/surgeon fees	20% (silver level)	40% (silver level)	

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If you need immediate medical attention	Emergency room services	10% (gold level) 20% (silver level) emergency care, after \$25 copay/visit 10% (gold level) 20% (silver level) non-emergency care, after \$25 copay/visit	10% (gold level) 20% (silver level) emergency care, after \$100 copay/visit 10% (gold level) 20% (silver level) non-emergency care, after \$100 copay/visit	Copayments waived if admitted directly to a hospital or facility on an inpatient basis.
	Emergency medical transportation	10% (gold level) 20% (silver level)	10% (gold level) 20% (silver level)	_____none_____
	Urgent care	10% (gold level) 20% (silver level)	30% (gold level) 40% (silver level)	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	10% (gold level) 20% (silver level)	30% (gold level) 40% (silver level)	Preauthorization required to receive coverage. Diagnostic services not covered unless medically necessary.
	Physician/surgeon fee			
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	10% (gold level)	30% (gold level)	Preauthorization required to receive coverage for inpatient services.
	Mental/behavioral health inpatient services	20% (silver level)	40% (silver level)	
	Substance use disorder outpatient services	10% (gold level)	30% (gold level)	Preauthorization required to receive coverage for inpatient services.
	Substance use disorder inpatient services	20% (silver level)	40% (silver level)	
If you are pregnant	Prenatal and postnatal care	10% (gold level)	30% (gold level)	_____none_____
	Delivery and all inpatient services	20% (silver level)	40% (silver level)	

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If you need help recovering or have other special health needs	Home health care	No charge	No charge	Preauthorization required to receive coverage. Coverage limited to 130 visits/year for combined network and out-of-network services.
	Rehabilitation services	10% (gold level) 20% (silver level)	30% (gold level) 40% (silver level)	Coverage limited to 60 inpatient days/year and 60 outpatient visits for all therapies combined, with progress review every 20 visits for out-of-network outpatient.
	Habilitation services	Not covered.	Not covered.	—————none—————
	Skilled nursing care	10% (gold level) 20% (silver level)	30% (gold level) 40% (silver level)	Preauthorization required to receive coverage.
	Durable medical equipment	10% (gold level) 20% (silver level)	30% (gold level) 40% (silver level)	Preauthorization required for expense of \$1,000 or more. Coverage for hearing aids limited to \$500 in 36 months.
	Hospice service	No charge	No charge	Preauthorization required to receive coverage. Coverage limited to 12-month lifetime maximum, 120-hour maximum for respite care in any 3-month period, and 12-month maximum for bereavement services.
If your child needs dental or eye care	Eye exam	Not covered.	Not covered.	—————none—————
	Glasses			
	Dental check-up	Not covered.	Not covered.	—————none—————

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|-------------------------|----------------------------|------------------------|
| • Cosmetic surgery | • Long-term care | • Routine foot care |
| • Dental care (Adult) | • Routine eye care (Adult) | • Weight loss programs |
| • Habilitation services | | |

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | |
|---------------------|---|
| • Acupuncture | • Infertility treatment |
| • Bariatric surgery | • Non-emergency care when traveling outside the U.S. See www.kingcounty.gov/employees/benefits/YourKingCountyBenefits . |
| • Chiropractic care | |
| • Hearing aids | • Private-duty nursing |

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 206-684-1556. You may also contact your state insurance department, the U.S. Department of Labor Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Aetna at 800-654-3250 or visit www.kingcare.com. For grievances and appeals regarding your drug coverage, call the number on the back of your pharmacy card or visit www.express-scripts.com. Additionally, a consumer assistance program can help you file your appeal. Contact the Washington Consumer Assistance Program at 800-562-6900 or cap@oic.wa.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

—————To see examples of how this plan might cover costs for a sample medical situation, see the next page.—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$6,972
- **Patient at gold out-of-pocket level pays** \$568

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient at gold out-of-pocket level pays:

Deductibles	\$50
Copays	\$28
Coinsurance	\$320
Limits or exclusions	\$170
Total	\$568

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$2,142
- **Patient at gold out-of-pocket level pays** \$3,258

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient at gold out-of-pocket level pays:

Deductibles	\$50
Copays	\$38
Coinsurance	\$240
Limits or exclusions	\$2,930
Total	\$3,258

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending accounts (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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